OMB#: 0935-0104

PATIENT ID: {HHRKUID}

PROVIDER ID: {PDDIRID}

PROVIDER NAME: {PROVNAME}

FORM _____ OF _____

{FORMNUM} {FORMTOT}

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

OFFICE-BASED PROVIDERS

FOR

REFERENCE YEAR 1998

(PATIENT NAME) reported that (he/she) received health care services from someone in this practice during the calendar year 1998.

B1. During this period, what is the (first/next) visit date in your records for (PATIENT NAME)? _____/_____/_____ MO DAY YR

IF GLOBAL FEE, RECORD TYPE:

Visit Date {EVNTBEGM} {EVNTBEGD} {EVNTBEGY}

GLOBAL FEE

B2a. Was the visit on (DATE) covered by a **global fee**, that is, was it included in a charge that covered services on other dates as well?

YES 1
NO 2 (B3)

[IF NECESSARY: *Examples would be a surgeon's fee covering surgery as well as pre- and post-operative care, or an obstetrician's fee covering normal delivery as well as pre- and post-natal care.*]

Yes, No {GLOFEE}

B2b. What other dates of service were covered by this global fee? Please include dates before or after 1998 if they were included in the global fee.

[IF THERE ARE MORE THAN 8 DATES, USE A CONTINUATION SHEET.]

Other Dates of Service {GFEEBEGM} {GFEEBEGD} {GFEEBEGY}

MO	DAY	YR	TYPE	IF TYPE 96, SPECIFY:
____	____	19 __	_____	_____
____	____	19 __	_____	_____
____	____	19 __	_____	_____
____	____	19 __	_____	_____
____	____	19 __	_____	_____
____	____	19 __	_____	_____
____	____	19 __	_____	_____
____	____	19 __	_____	_____

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B2c. Did (PATIENT NAME) receive the services on (DATE) in a:

Physician's Office (TYPE=MV);
Hospital as an Inpatient (TYPE=SH);
Hospital Outpatien Department (TYPE=SO);
Hospital emergency Room (TYPE=SE); or
Somewhere else (TYPE=96)

Global Fee Type {GFTYPE}
Global Fee Type Specify, Text {WHSPC}

B2d. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES 1
NO 2

Yes, No {GFEEFUTS}

GO TO B4a

B3. Did (PATIENT NAME) receive the services on (DATE) in a:

Physician's Office; 1
Hospital as an Inpatient; 2
Hospital Outpatient Department; 3
Hospital Emergency Room; or 4
Somewhere else?
(SPECIFY:)_____ 5
_____

Physician's Office,
Hospital as an Inpatient,
Hospital Outpatient Department,
Hospital Emergency Room,
Somewhere else, {RCSRV}
Somewhere else Specify, Text {RCSPC}

B4a. I need the diagnoses for (this visit/these visits). I would prefer the ICD-9 codes (or the DSM-4 codes), if they are available.

[IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]

[IF THERE ARE MORE THAN 8 DIAGNOSES, USE A CONTINUATION SHEET.]

Check box {CKBX#}
Condition Code Number {ICDCND#}
Condition Description, Text {ICDPDS#}

	CODE	DESCRIPTION
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____

|__|__| OFFICE USE ONLY

B4b. Which of these was the principal diagnosis?

Principal Diagnosis {ICDPRIN}

IF ONLY ONE DIAGNOSIS, GO TO B5a.
IF MORE THAN ONE DIAGNOSIS:
- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '-8' IF PRINCIPAL DIAGNOSIS NOT KNOWN ..... -8

B5a. I need the services provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

[IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

[IF THERE ARE MORE THAN 11 DIAGNOSES, USE A CONTINUATION SHEET.]

CPT-4 Code Number {MCPT#}
Description of Services, Text {MCPTDS#}

B5b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the **full established charge** for this service, before any adjustments or discounts?

[EXPLAIN IF NECESSARY: *The **full established charge** is the charge maintained in the physician's billing system for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.*]

[IF NO CHARGE: *Some practices that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a **"charge equivalent."** Could you give me the charge equivalents for these procedures?*]

Full Established Charge {MCPTCH#}

	CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent
a.	_____	$ _____.__
b.	_____	$_____.__
c.	_____	$_____.__
d.	_____	$_____.__
e.	_____	$_____.__
f.	_____	$_____.__
g.	_____	$_____.__
h.	_____	$_____.__
i.	_____	$_____.__
j.	_____	$_____.__
k.	_____	$_____.__

|__|__| OFFICE USE ONLY

C2. [IF NOT VOLUNTEERED, ASK:] And what was the total? [IF NOT AVAILABLE, COMPUTE.]

Total Charges {TOTLCHRG}

TOTAL CHARGES **$_____.__**

C3. Was the practice reimbursed for (this visit/these visits) on a fee-for-service basis or a capitated basis?

[EXPLAIN IF NECESSARY:]
Fee-for-service *means that the practice was reimbursed on the basis of the services provided.*

Capitated basis *means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.*

[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

Fee-for-Service Basis, Capitated Basis **{FEEORCAP}**

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS 2 (C7a)

C4. From what sources has the practice received payment for (this visit/these visits) and how much was paid by each source?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO Q7 AND CHANGE CODE TO 2 (CAPITATED BASIS).

Patient or Family	**{PATPAYM}**
Medicare	**{CAREPAYM}**
Medicaid	**{AIDPAYM}**
Private Insurance	**{PINSPAYM}**
VA Payment	**{VAPAYM}**
CHAMPVA/CHAMPUS	**{CHAMPAYM}**
Worker's Comp	**{WORKPAYM}**
Other	**{OTHRPAYM}**
Other Specify, Text	**{OTPAYMOS}**

a. Patient or patient's family $_____.___
b. Medicare $_____.___
c. Medicaid $_____.___
d. Private Insurance $_____.___
e. VA $_____.___
f. CHAMPVA/CHAMPUS $_____.___
g. WORKER'S COMP $_____.___
h. OTHER (SPECIFY): $_____.___
_____

C5. [IF NOT VOLUNTEERED, ASK:] And what was the total? [IF NOT AVAILABLE, COMPUTE.]

Total Payments **{TOTLPAYM}**

TOTAL PAYMENTS $_____.___

BOX 1
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES ..... 1 (BOX 2)
NO 2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

Adjustment or discount	
Medicare	{DISCARE}
Medicaid	{DISCAID}
Contractual arrangement	{DISCNT}
Courtesy discount	{DISCRTS}
Insurance write-off	{DISINSU}
Worker's Comp	{DISWORK}
Other	{DISOTH}
Other Specify, Text	{DISOTOS}
Expecting additional payment	
Patient or Family	{EPAYPAT}
Medicare	{EPAYCAR}
Medicaid	{EPAYAID}
Private Insurance	{EPAYPINS}
VA	{EPAYVA}
CHAMPVA/CHAMPUS	{EPAYCHAM}
Worker's Comp	{EPAYWORK}
Other	{EPAYOTH}
Other Specify, Text	{EPAYOTOS}
Charity care or sliding scale	{SLIDSCA}
Bad debt	{BADDEB}
Payments more than charges	
Medicare	{MORECARE}
Medicaid	{MORECAID}
Other	{PAYMOTH}
Other Specify, Text	{PAYMOTOS}

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment	1	2
b. Medicaid limit or adjustment	1	2
c. Contractual arrangement with insurer or managed care organization	1	2
d. Courtesy discount	1	2
e. Insurance write-off	1	2
f. Worker's Comp limit or adjustment	1	2
g. Other (Specify:)_____	1	2
Expecting additional payment		
h. Patient or Patient's Family	1	2
i. Medicare	1	2
j. Medicaid	1	2
k. Private Insurance	1	2
l. VA	1	2
m. CHAMPVA/CHAMPUS	1	2
n. WORKER'S COMP	1	2
o. Other (Specify:)_____	1	2
p. **Charity care or sliding scale**	1	2
q. **Bad debt**	1	2
PAYMENTS MORE THAN CHARGES: .		
r. Medicare Adjustment	1	2
s. Medicaid Adjustment	1	2
t. Private insurance adjustment	1	2
u. Other (Specify:)_____	1	2

GO TO BOX 2

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
a. Medicare;	{COVCARE}	1	2
b. Medicaid;	{COVAID}	1	2
c. Private Insurance;	{COVPINS}	1	2
d. VA;	{COVVA}	1	2
e. CHAMPVA/CHAMPUS;	{COVCHAM}	1	2
f. Worker's Comp; or	{COVWORK}	1	2
g. Something else? (SPECIFY:) _____	{COVOTHR}	1	2
Something else Specify, Text	{COVOTOS}		

C7b. Was there a co-payment for (this visit/these visits)?

YES	{ANYCOPAY}	1
NO		2 (C7e)

C7c. How much was the co-payment?

$_____.___ {COPAYAMT}

C7d. Who paid the co-payment?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
a. PATIENT OR PATIENT'S FAMILY	{CPAYPAT}	1	2
b. MEDICARE	{CPAYCARE}	1	2
c. MEDICAID	{CPAYAID}	1	2
d. PRIVATE INSURANCE	{CPAYPINS}	1	2
e. OTHER (SPECIFY:) _____	{CPAYOTHR}	1	2
Other Specify, Text	{CPAYOTOS}		

C7e. Do your records show any other payments for (this visit/these visits)?

YES	{OTHPAY}	1
NO		2 (BOX 2)

C7f. From what other sources has the practice received payment for (this visit/these visits) and how much was paid by each source?

IF NAME OF INSURER, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or patient's family	{OTHPAT}	$_____.___
b. Medicare	{OTHCARE}	$_____.___
c. Medicaid	{OTHAID}	$_____.___
d. Private Insurance	{OTHPINS}	$_____.___
e. VA	{OTHVA}	$_____.___
f. CHAMPVA/CHAMPUS	{OTHCHAM}	$_____.___
g. WORKER'S COMP	{OTHWORK}	$_____.___
h. OTHER (SPECIFY): _____	{OTHOTHR}	$_____.__
Other Specify, Text	{OTHOTOS}	

BOX2 {GOTORVIS}

BOX 2

GLOBAL FEE SITUATION (B2a=YES) 1 (B8)
RECORDED 5 OR FEWER EVENTS 2 (B8)
RECORDED 6 OR MORE EVENTS 3 (B6a)

REPEATING IDENTICAL VISITS

B6a. Were there any other visits for this patient during 1998 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)?

[EXPLAIN, IF NECESSARY: *We are referring here to **repeating identical visits**. These usually occur when the patient has a condition that requires very frequent visits, such as once- or twice-a-week physical or mental health therapy or weekly or monthly allergy shots.*]

Yes, No {OTHIDVIS}

YES 1
NO..... 2 (B8)

B6b. During 1998 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)?

Number of Identical Visits {VISNUM}

OF VISITS_____

B6c. Please tell me the dates of those other visits.
[IF THERE WERE MORE THAN 30 IDENTICAL VISITS, USE A CONTINUATION SHEET.]

Other Identical Visit Dates {EVNTBEGM} {EVNTBEGD} {EVNTBRGY}

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___

|__|__| OFFICE USE ONLY

B8. Have we covered all of this patient's visits during the calendar year 1998?

Yes, all events covered,
No, need to cover additional events {ALLEVNTS}

YES, ALL EVENTS COVERED..... 1 (B9a)
NO, NEED TO COVER ADDITIONAL EVENTS ..... 2 (B1-NEXT EVENT FORM)

B9a. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.

NO DIFFERENCE OR PROVIDER REPORTED MORE EVENTS THAN HOUSEHOLD..... 1 (B9b)

PROVIDER REPORTED FEWER EVENTS 2
PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 1998, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy?

_____
_____
_____

B9b. GO TO NEXT PATIENT FOR THIS PROVIDER.

B9c. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.